Continuing Your Medical and Dental Coverage Under Provisions of the Federal COBRA Law

Important note: The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law gives you and your covered dependents the right to continue employer-provided group health coverage on a self-paid basis for up to 18 months (and in some cases up to 36 months) after you would otherwise lose eligibility. This instruction sheet (a) describes your rights under the federal COBRA law, (b) specifies what you must do to maintain your coverage, and (c) lists the current premium rates for continuation of coverage.

Your right to COBRA continuation begins when a "qualifying event" occurs. This is an occurrence that causes you or a covered dependent to become ineligible for employer-provided coverage. Qualifying events are described in more detail on the following page. To exercise your COBRA right, you must submit an enrollment form within 60 days following the date of the qualifying event or the date on which you receive notice from your employer, whichever is later. Premiums must be paid retroactive to the first day of the month following the qualifying event. The law allows you and/or your dependents to continue your medical coverage only, medical and dental coverage together, or dental coverage only. You and each of your enrolled family members are entitled to make separate decisions about whether to continue coverage.

You and your dependents are not eligible for COBRA continuation if you or your dependents become covered under another group health plan after the date of the COBRA election, unless that plan contains a pre-existing condition exclusion or limitation that applies to the person covered. If such a limitation exists, you and your dependents may be eligible for COBRA coverage. When the pre-existing condition waiting period ends in the other plan covering you, your COBRA eligibility ends.

Please note: If you have left employment due to a disability, COBRA coverage may not be the only option available to you. Please contact the Health Care Authority (HCA) at 1-800-200-1004 for additional information.

Your Responsibility for Reporting Qualifying Events

You or your dependents also have responsibility under COBRA to provide notice to your employer within 60 days after a qualifying event occurs. If you are self-paying your insurance premium when the qualifying event occurs, you or your dependents must notify the HCA.

The Employer's Responsibility to You Under COBRA

The COBRA law requires your employer, the HCA, or retirement system to notify you and your dependents of your COBRA rights within 14 days of receiving your notification of a qualifying event. You may then exercise your COBRA rights by completing a COBRA enrollment form and sending it to the HCA within 60 days of the qualifying event or the date on which you receive notice of your rights, whichever is later. Along with the enrollment form, please send in the required premium. This will prevent delays in enrollment and/or claims processing. However, by law, you have up to 45 days from your COBRA enrollment date to pay your premiums.

"Qualifying Events" Under the COBRA Law

An employee and his/her covered dependents are entitled to continue Public Employees Benefits Board (PEBB)-sponsored health care coverage for up to 18 months on a self-paid basis if either of these events occurs:

(a) The employee is terminated from employment or terminates his or her employment for reasons other than gross misconduct, or

(b) The employee's hours of employment are reduced to the extent that eligibility for employer-provided medical and dental benefits would ordinarily be lost.

If an employee or an eligible dependent is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the continuation period can be extended for an additional 11 months for all covered individuals. In order to qualify for this extension, the qualified beneficiary must notify the HCA of the Social Security Administration's determination within 60 days of the determination and before the end of the original 18-month COBRA coverage period. For details on disability determination, call a Health Care Authority benefits specialist in Olympia at 360-412-4200 or toll-free at 1-800-200-1004.

The enrolled dependents of an employee are entitled to continue coverage for up to 36 months (and in some cases, longer) when any of these events occurs:

(a) The employee's death

(b) The spouse's divorce from the employee

(c) A child's loss of eligibility for dependent coverage

If you have questions about qualifying events under the COBRA law, contact the self-pay department of the Health Care Authority toll-free at 1-800-200-1004 or in Olympia at 360-412-4200.

How to Arrange Continuation of Coverage Under COBRA

By law, you and your dependents have 60 days in which to enroll under COBRA, and then 45 days from the date of enrollment under COBRA to make your first premium payment. **However, premiums must be paid retroactive to the first day of the month following the qualifying event.** To avoid a delay in obtaining benefits and the inconvenience of having to pay several months' premiums at the same time, it is to your advantage to send in your COBRA form and first month's payment immediately after you decide to continue coverage.

1. To continue group insurance coverage under COBRA, you or your eligible dependents must complete a new COBRA form that lists all persons to be covered under the terms of continuation. You and your dependents are not allowed to change medical or dental plans at the time you continue your benefits under COBRA. You will be allowed to change medical and dental plans only during an open enrollment period or when you move out of your plan's service area.

   If you elected to waive PEBB medical coverage as an eligible employee, you may re-enroll in a PEBB medical plan at the time you continue your benefits under COBRA.

If an eligible dependent of an employee elects to enroll in COBRA coverage after a qualifying event, (s)he should complete the COBRA form*, making sure that the employee's name and social security number appear in Section 1.

2. If you are eligible and want to continue your group coverage under COBRA by self-paying your premiums, follow the instructions on the next page.

   Send the completed form and a check for the first month's premium (based on the current COBRA rate schedule in this document) to:

   Washington State Health Care Authority
   P.O. Box 42695
   Olympia, WA 98504-2695

   Make checks payable to the Washington State Treasurer.

3. After you make your first payment, your premiums will be due on the 15th of each month of coverage, and will be past due on the 23rd. Late payment of your premium or return of your check for insufficient funds will be cause for cancellation of your coverage without notification, effective on the last day of the month in which the premium was paid in full.
4. If you wish to make any changes in your coverage while you are self-paying your premiums, contact the HCA, not your agency.
5. If you wish to terminate your coverage with the HCA, you must submit a written request. Termination will be effective the first day of the month following receipt of the termination notice.

When COBRA Continuation Ends

Your right to continue coverage under COBRA ends when any of the following occurs:

1. The COBRA continuation period ends.
2. The plan terminates.
3. COBRA premiums are not paid in a timely manner.
4. You regain eligibility for employer-paid coverage.
5. You or an enrolled dependent become covered under another group health plan after the date of the COBRA election. However, if the other plan contains a pre-existing condition exclusion or limitation that applies to the person covered, you may continue your COBRA coverage until the pre-existing condition waiting period ends in the other plan.
6. You send a written request to terminate coverage.

*Same-sex domestic partners need to complete a different form, available from the HCA. Call 1-800-200-1004.

Converting to an Individual Medical Policy

When your COBRA continuation period expires, you and your enrolled dependents are eligible for a conversion plan offered by your current health plan without providing evidence of good health unless you are covered under another group plan or Medicare. Application for conversion coverage must be made within 31 days from the date PEBB coverage ends. Uniform Medical Plan enrollees must apply through the HCA. Enrollees in other PEBB-sponsored health care plans must apply directly to their insurance plan.

If you or your dependents choose not to enroll in a conversion plan, your COBRA group coverage will end when your COBRA continuation period expires.

Where to Go for Assistance

1. *Within your agency or higher-education institution:* The payroll, personnel, or benefits department in your own agency or higher-education institution can assist you with forms and can answer general questions about eligibility for COBRA benefits.
2. *Within the Health Care Authority:* If you are unable to get the information you need from your agency or higher education institution, the HCA's benefits specialists can help answer your questions about HCA and PEBB policies, plan eligibility and enrollment, COBRA continuation, or conversion of coverage.

Call toll-free 1-800-200-1004
or 360-412-4200 in Olympia

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm data before making decisions.

To obtain this publication in another format (such as Braille or audio), contact our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), please call
360-923-2701 or toll-free 1-888-923-5622.

Public Employees Benefits Board (PEBB)

2003 COBRA Continuation of Medical and Dental Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- All covered family members must be included on this form.
- Make checks payable to the State Treasurer.

For dependents of employees ONLY

Employee name

Employee social security number | Date employer coverage ended (mm/dd/yyyy)

SECTION 1: Subscriber Information

Social security number | Sex ❑ M ❑ F | Last name | First name | Middle initial

Address | Apt./unit number

City | State | ZIP Code | County of residence

Date of birth (mm/dd/yyyy) | Work phone number (including area code) ( ) | Home phone number (including area code) ( )

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan for code.** ➡ Physician or clinic code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

Are you disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No

Are you covered by another group medical or dental plan? ❑ Yes ❑ No

If so, does that plan have a pre-existing condition clause, limitation, or exclusion? ❑ Yes ❑ No
If yes, submit a copy of the plan with this form.

Are you or your spouse or same-sex domestic partner enrolled in both Parts A & B of Medicare?
Subscriber: ❑ Yes ❑ No
Spouse or same-sex domestic partner: ❑ Yes ❑ No

Are you or your dependent(s) on Medicare disability? ❑ Yes ❑ No

Note: *If you or your dependents are Medicare eligible, you must be enrolled in Medicare Parts A and B. If you haven't sent in a copy of your Medicare card(s), please send a copy of it along with this form.*

SECTION 2: Family Member Information

List only family members you wish to cover.

Relationship to subscriber
❑ **Spouse** OR ❑ **Same-sex domestic partner**

Social security number | Physician or clinic code (contact plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

Other Family Members (such as child, grandchild, etc.) ***Use additional forms for more members***

A **Relationship to subscriber** | ❑ Disabled? ❑ Student? *(Check only if age 20 or older.)* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

SECTION 2: Family Member Information (continued)

B **Relationship to subscriber** | ❑ Disabled? ❑ Student? *(Check only if age 20 or older.)* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

SECTION 3: Changes
(Check all that apply.)

Subscriber changed: ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan

I wish to cancel **medical** coverage. ❑ Yes ❑ No

I wish to cancel **dental** coverage. ❑ Yes ❑ No

Change in family status:

❑ **Adding a spouse or same-sex domestic partner.** You **must** complete a Declaration, available from the Health Care Authority or online at www.pebb.hca.wa.gov.

❑ **Adding family member A**

❑ **Adding family member B**

❑ **Widowed** Date (mm/dd/yyyy)_____

❑ **Removing a spouse or same-sex domestic partner from coverage.** Please provide his/her new address, date of event, and reason:

Address _____

_____

Date (mm/dd/yyyy) _____

Reason _____

❑ **Removing other family members from coverage**

Name _____

Date (mm/dd/yyyy) _____

SECTION 4: Medical Plan Selection
(Check only one.)

❑ Group Health Cooperative of Puget Sound

❑ Group Health Options, Inc.

❑ Kaiser Foundation Health Plan of the Northwest

❑ PacifiCare of Washington, Inc.*

❑ Premera Blue Cross

❑ RegenceCare*

❑ Uniform Medical Plan

** These plans require the physician or clinic code of your selected primary care provider. Contact plan for code.*

SECTION 5: Dental Plan Selection
(Check only one.)

Preferred Provider Organization
(may receive services *from any provider*):

❑ Uniform Dental Plan (Group #3000)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Columbia Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

SECTION 6: Signature (Required)

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I certify that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all previous forms I have submitted for Public Employees Benefits Board medical/dental coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____
Subscriber's signature Date

Please sign and date this form.

Return form and check to:
Washington State Health Care Authority,
P.O. Box 42695, Olympia, WA 98504-2695

Washington State Health Care Authority
Public Employees Benefits Board

Visit our Web site at www.pebb.hca.wa.gov

For Agency Use Only ❑ 18-month (Terminated or reduction in hours) ❑ 29-month (Approved disability [SSI]) ❑ 36-month (Spouse/child: loss of dependent eligibility)